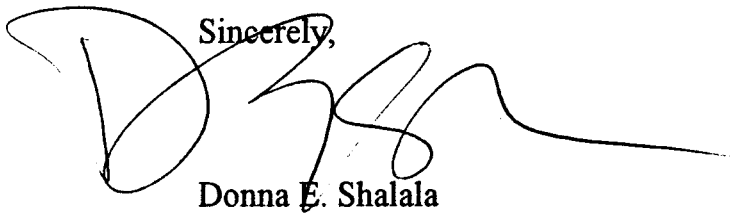
3.2 percent for the excluded hospital market basket increase. Therefore, depending on the hospital's costs in relation to its limit, the update would be the market basket increase minus a percentage between 0 and 2.5 percentage points, or 0, resulting in an increase in the TEFRA limits of between .7 and 3.2 percent, or 0.

My recommendation for the updates is based on cost projections used in the President's FY 2001 budget. A final recommendation on the appropriate percentage increases for FY 2001 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest of all relevant factors, including recommendations by the Medicare Payment Advisory Commission.

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time, I do not anticipate recommending any adjustment to the DRG weighting factors for FY 2001.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the Speaker of the House of Representatives.

Sincerely,



Donna E. Shalala

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 17 2000

The Honorable J. Dennis Hastert
Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Section 1886(e)(3) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in hospital inpatient payment rates for fiscal year (FY) 2001 that I will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

Current law mandates, and the President's FY 2001 budget includes, an update for PPS hospitals, except sole community hospitals (SCHs), equal to the market basket minus 1.1 percentage points. The update for SCHs in current law and the President's 2001 budget is equal to the market basket rate of increase. The President's FY 2001 budget estimated the PPS market basket rate of increase for FY 2001 to be 3.2 percent. Based on this estimate, we recommend an update for SCHs of 3.2 percent and for other hospitals in both large urban and other areas of 2.1 percent.

SCHs are the sole source of care in their area and are afforded special payment protection in order to maintain access to services for Medicare beneficiaries. Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their area and are afforded special payment protection in order to maintain access to services for beneficiaries. SCHs and MDHs are PPS hospitals. However, SCHs are paid the higher of a hospital-specific rate or the Federal PPS rate, and MDHs are paid the Federal PPS rate, or, if their hospital-specific rate exceeds the Federal PPS rate, the Federal rate plus 50 percent of the difference between the hospital-specific rate and the Federal rate. We recommend an update of 3.2 percent to the SCH hospital-specific rate and 2.1 percent to the MDH hospital-specific rate.

Hospitals and distinct part hospital units excluded from PPS are paid based on their reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Current law mandates that the update for all hospitals and distinct part units excluded from PPS equals the rate of increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit, or 0 if costs do not exceed two-thirds of the limit. The

Page 2 - The Honorable J. Dennis Hastert

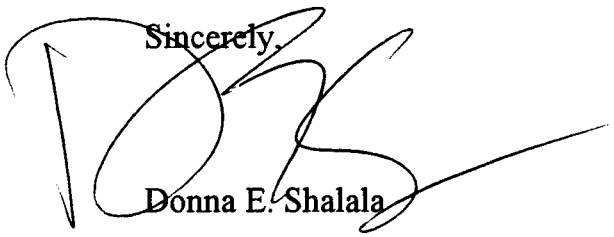
President's FY 2001 budget incorporates an increase to the TEFRA limit using 3.2 percent for the excluded hospital market basket increase. Therefore, depending on the hospital's costs in relation to its limit, the update would be the market basket increase minus a percentage between 0 and 2.5 percentage points, or 0, resulting in an increase in the TEFRA limits of between .7 and 3.2 percent, or 0.

My recommendation for the updates is based on cost projections used in the President's FY 2001 budget. A final recommendation on the appropriate percentage increases for FY 2001 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest of all relevant factors, including recommendations by the Medicare Payment Advisory Commission.

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time, I do not anticipate recommending any adjustment to the DRG weighting factors for FY 2001.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the President of the Senate.

Sincerely,



Donna E. Shalala

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Appendix D: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Several provisions of the Act address the setting of update factors for inpatient services furnished in FY 2001 by hospitals subject to the prospective payment system and by hospitals or units excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XVI) of the Act sets the FY 2001 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 1.1 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2001 percentage increase in the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act. For Medicare-dependent, small rural hospitals, the percentage increase is the same update factor as all other hospitals subject to the prospective payment system, or the rate of increase in the market basket minus 1.1 percentage points. Section 406 of Public Law 106–113 amended section 1886(b)(3)(B)(i) of the Act to provide that, for sole community hospitals, the rate of increase in the hospital-specific rates for FY 2001 only is equal to the market basket percentage increase. Prior to FY 2001, sole community hospitals were subject to the same percentage increase to their hospital-specific rates as all other hospitals subject to the prospective payment system set forth in section 1886(b)(3)(B)(i) of the Act.

Under section 1886(b)(3)(B)(ii) of the Act, the FY 2001 percentage increase in the rate-of-increase limits for hospitals and units excluded from the prospective payment system ranges from the percentage increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available, or 0 percentage point if costs do not exceed two-thirds of the limit.

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals and units excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the first quarter 2000 forecast of the FY 2001 market basket increase of 3.1 percent for hospitals and units subject to the prospective payment system, the proposed update to the standardized amounts is 2.0 percent (that is, the market basket rate of increase minus 1.1 percent percentage points) for hospitals in both large urban and other areas. The proposed update to the hospital-specific rate applicable to Medicare-dependent, small rural hospitals is also 2.0 percent. The proposed update to the hospital-specific rate applicable to sole community hospitals is 3.1 percent. The proposed update for hospitals and units excluded from the prospective payment system would range from the percentage increase in the excluded hospital market basket (currently estimated at 3.1 percent) minus a percentage between 0 and 2.5 percentage points, or 0 percentage point, resulting in an increase in the rate-of-increase limit between 0.6 and 3.1 percent, or 0 percent.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the update factors recommended under section 1886(e)(4) of the Act. Accordingly, this appendix provides the recommendations of appropriate update factors and the analysis underlying our recommendations.

In its March 1, 2000 report, MedPAC did not make a specific update recommendation for FY 2001 payments for Medicare acute inpatient hospitals. However, at its April 13, 2000 public meeting, MedPAC announced that it was recommending a combined update between 3.5 percent and 4.0 percent for operating and capital-related payments for FY 2001. This recommendation is higher than the current law amount as prescribed by Public Law 105–33 and proposed in this rule. Because of the timing of the announcement and our need for ample time to perform a proper analysis of the recommendation, we will address the comparison of HCFA's update recommendation and MedPAC's update recommendation in the FY 2001 final rule in August 2000 when we will have had the opportunity to review the data analyses that substantiate MedPAC's recommendation.

We describe the basis for our FY 2001 update recommendation (Table 1) in section II. of this Appendix.

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, we are recommending that an appropriate update factor for the standardized amounts is 2.0 percentage points for hospitals located in large urban and other areas. We are also recommending an update of 2.0 percentage points to the hospital-specific rate for Medicare-dependent, small rural hospitals. In addition, we are recommending an update of 3.1 percentage points to the hospital-specific rate for sole community hospitals. We believe these recommended update factors would ensure that Medicare acts as a prudent purchaser and provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

We recommend that hospitals excluded from the prospective payment system receive an update of between 0.6 and 3.1 percentage points, or 0 percentage points. The update for excluded hospitals and units is equal to the increase in the excluded hospital operating market basket less a percentage between 0 and 2.5 percentage points, or 0 percentage points, depending on the hospital's or unit's costs in relation to its rate-of-increase limit for the most recent cost reporting period for which information is available. The market basket rate of increase for excluded hospitals and units is currently forecast at 3.1 percent.

Our update recommendation of 2.0 percent (market basket increase minus 1.1 percent) for prospective payment system operating costs standardized amounts is supported by the following analyses that measure changes in hospital productivity, scientific and technological advances, practice pattern changes, and changes in case-mix:

A. Productivity

Service level productivity is defined as the ratio of total service output to full-time equivalent employees (FTEs). While we recognize that productivity is a function of many variables (for example, labor, nonlabor material, and capital inputs), we use a labor productivity measure since this update framework applies to operating payment. To recognize that we are apportioning the short-run output changes to the labor input and not considering the nonlabor inputs, we weight our productivity measure for operating costs by the share of direct labor services in the market basket to determine the expected effect on cost per case.

Our recommendation for the service productivity component is based on historical trends in productivity and total output for both the hospital industry and the general economy, and projected levels of future hospital service output. MedPAC's predecessor, the Prospective Payment Assessment Commission (ProPAC), estimated cumulative service productivity growth to be 4.9 percent from 1985 through 1989, or 1.2 percent annually. At the same time, ProPAC estimated total output growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35.

Since it is not possible at this time to develop a productivity measure specific to Medicare patients, we examined productivity (output per hour) and output (gross domestic product) for the economy. Depending on the exact time period, annual changes in productivity range from 0.3 to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with a 0.3 to 0.35 percent change in output per hour).

Under our framework, the recommended update is based in part on expected productivity—that is, projected service output during the year, multiplied by the historical ratio of service productivity to total service output, multiplied by the share of labor in total operating inputs, as calculated in the hospital market basket. This method estimates an expected labor productivity improvement in the same proportion to expected total service growth that has occurred in the past and assumes that, at a minimum, growth in FTEs changes proportionally to the growth in total service output. Thus, the recommendation allows for unit productivity to be smaller than the historical averages in years that output growth is relatively low and larger in years that output growth is higher than the historical averages. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the

range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, expected quality-enhancing intensity growth, and net of expected decline in intensity due to reduction of cost-ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Thus, expected output growth is simply the sum of the expected change in intensity (0.0 percent), projected admissions change (1.6 percent for FY 2001), and projected real case-mix growth (0.5 percent), or 2.1 percent. The share of direct labor services in the market basket (consisting of wages, salaries, and employee benefits) is 61.4 percent.

Multiplying the expected change in total hospital service output (2.1 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage 61.4, provides our productivity standard of −0.5 to −0.4 percent.

B. Intensity

We base our intensity standard on the combined effect of three separate factors: changes in the use of quality enhancing services, changes in the use of services due to shifts in within-DRG severity, and changes in the use of services due to reductions of cost-ineffective practices. For FY 2001, we recommend an adjustment of 0.0 percent. The basis of this recommendation is discussed below.

We have no empirical evidence that accurately gauges the level of quality-enhancing technology changes. A study published in the Winter 1992 issue of the *Health Care Financing Review,* ''Contributions of case mix and intensity change to hospital cost increases'' (pp. 151–163), suggests that one-third of the intensity change is attributable to high-cost technology. The balance was unexplained but the authors speculated that it is attributable to fixed costs in service delivery.

Typically, a specific new technology increases cost in some uses and decreases cost in other uses. Concurrently, health status is improved in some situations while in other situations it may be unaffected or even worsened using the same technology. It is difficult to separate out the relative significance of each of the cost-increasing effects for individual technologies and new technologies.

Other things being equal, per-discharge fixed costs tend to fluctuate in inverse proportion to changes in volume. Fixed costs exist whether patients are treated or not. If volume is declining, per-discharge fixed costs will rise, but the reverse is true if volume is increasing.

Following methods developed by HCFA's Office of the Actuary for deriving hospital output estimates from total hospital charges, we have developed Medicare-specific intensity measures based on a 5-year average using FYs 1995 through 1999 MedPAR billing data. Case-mix constant intensity is calculated as the change in total Medicare charges per discharge adjusted for changes in the average charge per unit of service as measured by the CPI for hospital and related services and changes in real case-mix. Thus, in order to measure changes in intensity, one must measure changes in real case-mix.

For FYs 1995 through 1999, observed case-mix index change ranged from a low of −0.3 percent to a high of 1.7 percent, with a 5-year average change of 0.6 percent. Based on evidence from past studies of case-mix change, we estimate that real case-mix change fluctuates between 1.0 and 1.4 percent and the observed values generally fall in this range, although some years the figures fall outside this range. The average percentage change in charge per discharge was 3.6 percent and the average annual change in the CPI for hospital and related services was 4.1 percent. Dividing the change in charge per discharge by the quantity of the real case-mix index change and the CPI for hospital and related services yields an average annual change in intensity of −1.9 percent. Assuming the technology/fixed cost ratio still holds (.33), technology would account for a −0.6 percent annual decline while fixed costs would account for a −1.3 percent annual decline. The decline in fixed costs per discharge makes intuitive sense as volume, measured by total discharges, has increased during the period. In the past, we have not recommended a negative intensity adjustment. Although we are not recommending a negative adjustment for FY 2001, we are reflecting the possible range that such a negative adjustment could span, based on our analysis. Accordingly, for FY 2001, we are recommending an intensity adjustment between 0 percent and −0.6 percent.

C. Change in Case-Mix

Our analysis takes into account projected changes in case-mix, adjusted for changes attributable to improved coding practices. For our FY 2001 update recommendation, we are projecting a 0.5 percent increase in the case-mix index. We define real case-mix as actual changes in the mix (and resources requirements) of Medicare patients as opposed to changes in coding behavior that results in assignment of cases to higher weighted DRGS, but do not reflect greater resource requirements. Unlike in past years, where we differentiated between ''real'' case-mix increase and increases attributable to changes in coding behavior, we do not feel changes in coding behavior will impact the overall case-mix in FY 2001. As such for FY 2001, we estimate that real case-mix is equal to projected change in case-mix. Thus, we are recommending a 0.0 adjustment for case-mix.

D. Effect of FY 1999 DRG Reclassification and Recalibration

We estimate that DRG reclassification and recalibration for FY 1999 resulted in a 0.0 percent change in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER.

E. Forecast Error Correction

We make a forecast error correction if the actual market basket changes differ from the forecasted market basket by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of forecast error. Our update framework for FY 2001 does not reflect a forecast error correction because, for FY 1999, there was less than a 0.25 percentage point difference between the actual market basket and the forecasted market basket.

As we explained in section I. of this Appendix, a comparison of our update recommendation to MedPAC's recommendation is unavailable for this proposed rule. MedPAC did not announce its recommendation for a combined update of between 3.5 percent and 4.0 percent for operating and capital-related payments for FY 2001 until its April 13, 2000 public meeting. This recommendation is higher than the current law amount as prescribed by Public Law 105–33 and proposed in this rule. Because of the timing of the announcement and our need for ample time to perform a proper analysis of the recommendation, we will address the comparison of HCFA's update recommendation and MedPAC's update recommendation in the FY 2001 final rule in August 2000 when we will have had the opportunity to review the data analyses that substantiate MedPAC's recommendation. The following is a summary of the update range supported by our analyses:

TABLE 1.—HHS' FY 2001 UPDATE RECOMMENDATION

Market basket	MB
Policy Adjustments Factors:	
Productivity	−0.5 to −0.4
Intensity	0.0 to −0.6
Subtotal	−0.5 to −1.0
Case-Mix Adjustment Factors:	
Projected Case-Mix Change	−0.5
Real Across DRG Change	0.5
Subtotal	0.0
Effect of 1999 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Recommended Update	MB −0.5 to MB −1.0

Consistent with current law, we are recommending an update of market basket increase minus 1.1 percentage points (or 2.0 percent). We note that this approximates the lower bound of the range suggested by our framework when accounting for a negative intensity change.

For FY 2001, we believe that a 2.0 update factor appropriately reflects current trends in health care delivery, including the recent decreases in the use of hospital inpatient services and the corresponding increase in the use of hospital outpatient and postacute care services. We also recommend that the hospital-specific rates applicable to Medicare-dependent, small rural hospitals be increased by the same update, 2.0 percentage points. Furthermore, we recommend that the hospital-specific rates applicable to sole community hospitals be increased by an update of 3.1 percentage points.

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